

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-011423-

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUD

AMENDED

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 46

FILED MAR 20 1963

VS 300  
Rev. 4/59

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Howell</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>West Plains</u>		c. CITY OR TOWN <u>West Plains</u>	
c. FULL NAME OF (If NOT in hospital, give location) <u>W.P. Memorial Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>1123 Grace Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Marion Earl Gentry</u>		4. DATE OF DEATH <u>March 3, 1963</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-8-1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired farmer</u>		11. BIRTHPLACE (City and state or country) <u>Hornersville, Ind.</u>	
13a. FATHER'S NAME <u>Manson Gentry</u>		14. NAME OF HUSBAND OR WIFE <u>Mildred Stuart</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates)		17. INFORMANT <u>Mildred Gentry, West Plains, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia, bilateral</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I <u>Hemiplegia, left, old CVA</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>4:15</u> a.m. p.m. Month, Day, Year <u>1956</u>		20f. CITY, TOWN, OR LOCATION <u>West Plains, Mo.</u>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21. I attended the deceased from <u>4-15</u> <u>1956</u> to <u>3-3-63</u> and last saw him alive on <u>3-3-63</u>		22a. SIGNATURE <u>Dr. R. Wiles, M.D.</u>	
22b. ADDRESS <u>West Plains, Mo.</u>		22c. DATE SIGNED <u>3-8-63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>3-5-63</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		23d. LOCATION (City, town, or county) <u>West Plains, Mo.</u>	
24. FUNERAL DIRECTOR <u>Robertsons, West Plains, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>3-12-63</u>	
26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>			

USE BLACK INK  
OR  
TYPEWRITER RIBBON

Wiles

MAR 21 1963

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*A. H. Robertson*

Licensed Embalmer No. 3432

P. O. Address West Plains, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.